State of Tennessee
Division of Claims Administration
502 Deaderick Street
Nashville, Tennessee 37243-0202
Telephone: (615) 741-2734
Fax: (615) 532-4979
Website: www.tn.gov/treasury/injury
E-mail: Criminal.Injury@state.tn.us

TENNESSEE'S CRIMINAL INJURIES COMPENSATION

PURPOSE AND INSTRUCTIONS

Purpose

The purpose of the Criminal Injuries Compensation Program is to assist victims of crimes or, in the case of the victims' death, their dependent family members in paying out-of-pocket expenses that are a direct result of personal injuries sustained by a criminal offense.

The State of Tennessee is committed to helping victims who meet the eligibility requirements of the Tennessee Criminal Injuries Compensation Act. While no amount of financial aid can erase the trauma of crime, it is the goal of this program to ease the aftermath of crime for the victim whenever possible.

Instructions for Completing and Filing a Claim

- ☑ File a claim within one year of the date of injury, unless the victim of crime is a child (who has until age 19 to file). If the person seeking compensation is under age 18, his/her legal guardian must act as claimant.
- ☑ Seek any amounts the victim/claimant is legally entitled to receive as a result of the injuries from any other public or private source. This includes insurance, Medicaid, Medicare, workers' compensation, etc. If the amounts received from other sources do not cover all eligible losses and expenses, then criminal injuries compensation may apply. This is a fund of last resort.
- ☑ Read all instructions when completing the form. Answer ALL questions. If the question does not apply, please mark it N/A. If you need help with this form, call (615) 741-2734.
- ☑ Type or print legibly with INK. Use additional sheets if necessary.
- ☑ Attach a copy of the law enforcement report to prove the crime occurred and was reported to the proper authorities.
- ☑ Attach itemized copies of ALL bills, receipts, insurance/benefit statements and any other documentation to support the claim.
- ☑ COMPLETE all pages of the application. The form must be SIGNED AND NOTARIZED, otherwise, the claim processing will be delayed.
- ☑ Submit the ORIGINAL application form plus one copy to the Division at the above address. The claim is not "filed" until the Division receives it.
- ☑ Respond as soon as possible to any written notices from the Division so that your claim can be processed. The Division will send a written notice of the eligibility decision on the claim.
- ☑ Notify the Division of Claims Administration immediately regarding any change of address for the claimant or attorney while the claim is pending. **The claim may be denied if you do not inform us of a change of address and we have no valid contact information**.

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FOR OFFICE USE ONLY
CLAIM # _____

Reset Form

CRIMINAL INJURIES COMPENSATION APPLICATION

SECTION A

You are filing this claim because you are:

- ☐ The victim of a crime.
- ☐ The guardian of a crime victim who is under 18 years of age. If so, supply a copy of child's birth certificate or a copy of the guardianship papers if you are not the child's parent.
- ☐ The guardian of a crime victim who is incompetent. If so, submit a copy of the guardianship/conservatorship papers.
- ☐ The dependent of a deceased crime victim. A dependent means a family member who was receiving substantial support or needed services from the victim at the time of the victim's death. If so, supply proof of your relationship (e.g. marriage certificate, birth certificate, etc.)
- ☐ The guardian of a dependent who is under 18 years of age. If so, supply a copy of child's birth certificate and a copy of the guardianship papers.
- ☐ The guardian of a dependent who is incompetent. If so, submit a copy of the guardianship/conservatorship papers.
- ☐ The victim or victim's relative who has paid or who is required to pay the crime scene cleanup expenses or funeral and burial expenses.

Indicate the benefits you are requesting. Attach fully itemized bills to document all expenses being claimed, including documentation of payments made by you or other sources.

- ☐ Medical bills.
- ☐ Mental health counseling bills. Services must be for the victim or, in some cases, a victim's relative.
- ☐ Lost wages.
- ☐ Permanent impairment. Provide a doctor's statement with your impairment rating due to the injury from this crime.
- ☐ Funeral and/or burial expenses.
- ☐ Crime scene cleanup expenses (available only under certain circumstances).
- ☐ Loss of support to dependents (in case of victim's death).
- ☐ Pain and suffering (**ONLY** for a victim of a sexually-oriented crime). (*NOTE: Sexual assault forensic medical examinations for crimes committed on or after July 1, 2007 are to be billed by and sent in by the facility that provided the services.*)
- ☐ Moving expenses (**ONLY** for a victim if the crime occurred in primary residence and the move is directly related to the crime).
- ☐ Trial travel expenses (to attend trial of defendant unless person is eligible for witness fees).

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SECTION B – VICTIM INFORMATION *(Provide all requested information pertaining to the victim who received the injuries.)*

Victim's Name _____
(Last) (First) (Maiden) (Middle)

Address _____
(Street) (Apt.)

_____
(City) (County) (State) (Zip Code)

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Date of Birth __ __/__ __/ __ __ __ __ Age at Time of Crime _____ Social Security # __ __ __ __ __ __ __ __ __

The following victim information is used for statistical purposes only.			
Mentally Disabled?	☐ No ☐ Yes		
Physically Disabled?	☐ No ☐ Yes		
Race	☐ White	☐ Black	☐ Hispanic
	☐ Spanish American	☐ Asian American	☐ American Indian
	☐ Other (specify) _____		
Religion	☐ Catholic	☐ Jewish	
	☐ Islamic	☐ Protestant (Baptist, Methodist, etc.)	
	☐ Agnostic / Atheist	☐ Other (specify) _____	
Who referred you to us?	☐ Law Enforcement Agency	☐ Social Services	☐ Media (TV, radio, etc.)
	☐ Hospital	☐ Prosecutor / Victim Witness Program	
	☐ Posters / Brochures	☐ Other (specify) _____	
Sex	☐ Female ☐ Male		
National Origin	☐ United States ☐ Other _____		

(IF YOU ARE THE VICTIM <u>AND</u> YOU ARE OVER AGE 18, SKIP TO SECTION D.)

SECTION C – CLAIMANT INFORMATION *(Only complete this section if you <u>are</u> <u>not</u> the victim.)*

Claimant's Name _____ _____
(Last) (First) (Middle) (Relationship to Victim)

Address _____
(Street) (Apt.)

_____
(City) (County) (State) (Zip Code)

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Date of Birth __ __/__ __/ __ __ __ __ Social Security # __ __ __ __ __ __ __ __ __

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SECTION D – CRIME INFORMATION *(You must provide the date of the crime and county and state where the crime occurred. You can obtain the information from the responding law enforcement agency. If the crime was not reported within 48 hours, submit a written statement explaining such.)*

Type of Crime (check one):

- ☐ Murder / Homicide 0001
- ☐ Adult Sexual Assault 0002
- ☐ Robbery by Force 0003
- ☐ Assault 0004
- ☐ Vehicular (Non-DUI) 0006
- ☐ Child Physical Abuse 0007
- ☐ Child Sex Abuse 0008
- ☐ Other (specify) 0009 _____
- ☐ Drunk Driver 0010
- ☐ Stalking 0011
- ☐ Terrorism 0012
- ☐ Kidnapping 0013
- ☐ Arson 0014
- ☐ Hit and Run 0015 *(excluding property damage)*

Was the crime domestic violence? ☐ No ☐ Yes

Date of Crime __ __/__ __/__ __ __ __ Date Crime Reported to Law Enforcement __ __/__ __/__ __ __ __

Was the injury to or death of the victim caused by a motor vehicle? ☐ No ☐ Yes

Location of Crime _____

(Street) *(City)* *(County, required)* *(State, required)*

Please describe what happened and the injuries suffered as a result. Attach a copy of the police report. If the victim is deceased, also attach a copy of death certificate.

Name and address of offender(s), if known. (By law, we are required to notify offender(s) of this claim.)

Did the victim know offender(s)? ☐ No ☐ Yes If yes, in what way? _____

Was the victim living in the same house with the offender at the time of the crime? ☐ No ☐ Yes

Does the victim still live with the offender? ☐ No ☐ Yes

Who is handling your case? ☐ State prosecutor ☐ Federal prosecutor

Has the court ordered the offender to pay you for your financial losses? ☐ No ☐ Yes ☐ Unknown
If yes, attach a copy of the order of restitution.

Have you filed or do you plan to file a lawsuit for your injuries? ☐ No ☐ Yes ☐ Unknown
If yes, and you are represented by an attorney, please provide the attorney's name and telephone number:

_____

SECTION E – INSURANCE AND FINANCIAL ASSISTANCE

Is there any insurance coverage to assist with the expenses being claimed? ☐ No ☐ Yes

If yes, please check below the benefits that have been paid (or may be paid) in part or in full for any expenses you are claiming. Also, provide information to document payments made.

- ☐ Automobile Insurance
- ☐ Burial Insurance
- ☐ Life Insurance
- ☐ Homeowner's Insurance
- ☐ Offender / Court-Ordered Restitution
- ☐ Social Security (death benefits, disability, etc.)
- ☐ Donations
- ☐ Health Insurance
- ☐ Medicare / Medicaid / TennCare
- ☐ Disability
- ☐ Sick Pay
- ☐ Vacation / Annual Pay
- ☐ Veterans Administration / Insurance
- ☐ Workers' Compensation
- ☐ Other (specify) _____

(Go to page 4.)

SECTION F – LOST WAGES OR LOSS OF SUPPORT FOR DEPENDENTS *(Complete this section only if victim was employed at the time of injury or death. Information is needed to verify lost wages or financial support provided to dependents.)*

Lost Wages

Did the victim miss work due to injuries? ☐ No ☐ Yes

If yes, please have the employer(s) complete an Employer's Statement form. If the victim missed more than two weeks of work, please provide a doctor's statement.

Is/was the victim self-employed? ☐ No ☐ Yes

If yes, submit the most recent income tax return or statements from those for whom the victim worked, showing amount(s) paid and date(s) for a period of at least 12 months prior to the crime. If the victim missed more than two weeks of work, please provide a doctor's statement.

Loss of Support for Dependents

Did the victim contribute financial support to any dependents at the time of death? ☐ No ☐ Yes

If yes, submit proof of relationship of claimant(s) to the victim and provide documentation that the victim substantially supported the claimant(s) at the time of death (e.g., tax returns, receipts, court-ordered support). Also, attach verification of the victim's income at the time of death (e.g., employer's statement, W-2 form or tax return).

Provide names of the deceased victim's dependents for whom you are filing a loss of support claim. Attach additional sheets if necessary.

Name	Street Address	City / State / Zip	Relationship to Victim	Birth Date

Did the victim leave other dependents who are **not** listed above? ☐ No ☐ Yes

If yes, provide the names and addresses below.

Name	Street Address	City / State / Zip	Relationship to Victim	Birth Date

(Go to page 5.)

SECTION G – AUTHORIZATION AND SUBROGATION

VERIFICATION OF APPLICATION: I hereby certify, subject to the penalty of fine and imprisonment, that the information contained in this application for criminal injuries compensation is true and correct to the best of my knowledge.

SUBROGATION: In consideration of the payment received from the Criminal Injuries Compensation Fund, I agree to repay the Fund the full amount I (or my child or ward) received from the Fund in the event I (or my child or ward) recover damages or compensation from the offender or from any other public or private source as a result of the injuries or death which was the basis of my claim for compensation from the Fund. For purposes of this Agreement, I understand that compensation from "any other public or private source" includes, but is not limited to, receipt of insurance, Medicare, Medicaid, TennCare, workers' compensation, disability pay, etc. I further agree and understand that no part of the recovery due the Criminal Injuries Compensation Fund may be diminished by any collection fees or for any other reason whatsoever. Should I (or my child or ward) choose to recover damages or compensation for the injury or death from any source, I agree to promptly notify the District Attorney General in the district where the crime occurred and the Criminal Injuries Compensation Program by sending to the District Attorney General and the Compensation Program copies of any pleadings, settlement proposals and any other documents relative thereto. I further agree to fully cooperate with the State of Tennessee should the State institute an action against any person or entity for the recovery of all or any part of the compensation I (or my child or ward) received from the Fund.

RELEASE OF INFORMATION AUTHORIZATION: I hereby authorize any hospital, physician, funeral director, municipal authority, employer or union, insurance company, social service bureau, Social Security office, or any other person, firm, agency, or organization to furnish to the Tennessee Criminal Injuries Compensation Fund, or its representative, any information requested, including tax data and prior police records, needed to perfect my claim for compensation. A photocopy of this authorization shall be considered as effective and valid as the original.

PUBLIC RECORDS: Except as otherwise provided by applicable federal or state law, the information contained in this application and all documents submitted in support of your claim are subject to the Public Records Laws of the State of Tennessee pursuant to Tennessee Code Annotated, Title 10, Chapter 7, Part 5.

I certify that I have read and/or understand and agree to the above statements.

_____ _____

Victim / Claimant's Signature *Date*

State of _____ / County of _____

Sworn to and subscribed before me the undersigned Notary on this the _____ day of _____, 20____.

(SEAL) *Notary Public* _____

My Commission Expires: _____

SECTION H – ATTORNEY INFORMATION

You do not need to be represented by an attorney to apply for and receive compensation. If you need assistance in completing this application, please call us at (615) 741-2734. However, if you feel it is necessary to have an attorney complete the application, this section must be completed. The name, address, telephone number and tax identification number of the attorney must be provided and the attorney must sign the application.

Attorney's Name _____

(Last) (First) (Middle)

Address _____

(Street) (City) (County) (State) (Zip Code)

Phone Number _____ FEIN or Social Security # __ __ __ __ __ __ __ __ __

Attorney Certification - I hereby certify that I have been retained by and represent the victim and/or claimant filing this application. I further certify that I have read through this entire application with such person and that such person indicated that he/she understood every question and provision contained herein.

_____

Attorney's Signature / Date